provide the level of care for which payment is being made, or, if the facility is located outside the state of Montana, comply with the provisions of ARM 37.40.337;

(e) operate under the direction of a licensed nursing home administrator, or other qualified supervisor for the facility, as applicable laws, regulations, rules or policies may require;

(f) for providers maintaining resident trust accounts, insure that any funds maintained in such accounts are used only for those purposes for which the resident, legal guardian, or personal representative of the resident has given written authorization. The provider must maintain personal funds in excess of $50 in an interest bearing account and must credit all interest earned to the resident's account. Resident's personal funds in amounts up to $50 must be maintained in such a manner that the resident has convenient access to such funds within a reasonable time upon request. A provider may not borrow funds from such accounts or commingle resident and facility funds for any purpose;

(g) A provider holding personal funds of a deceased nursing facility resident who received medicaid benefits at any time shall, within 30 days following the resident's death, pay those funds as provided by law and regulation.

(h) maintain admission policies which do not discriminate on the basis of diagnosis or handicap, and which meet the requirements of all federal and state laws prohibiting discrimination against the handicapped, including persons infected with acquired immunity deficiency syndrome/human immunodeficiency virus (AIDS/HIV);

(i) comply with ARM 37.40.101, 37.40.105, 37.40.106, 37.40.110, 37.40.120 and 37.40.201 through 37.40.207, regarding screening for nursing facility services;

(j) comply with all applicable federal and state laws, rules, regulations and policies regarding nursing facilities at the times and in the manner required therein, including but not limited to 42 USC 1396r(b)(5) and 1396r(c) (1994 supp.) and implementing regulations, which contain federal requirements relating to nursing home reform. The department hereby adopts and incorporates herein by reference 42 USC 1396r(b)(5) and 1396r(c). A copy of these statutes may be obtained from the Department of Public Health and Human Services, Senior and Long Term Care Division, 111 N. Sanders, P.O. Box 4210, Helena, MT

59604-4210.

(2) A provider which fails to meet any of the requirements of this rule may be denied medicaid payments, refused further participation in the medicaid program or otherwise sanctioned or made subject to appropriate department action, according to applicable laws, rules, regulations or policies.

(a) Subject to applicable federal law and regulations, the department may impose a sanction or take other action against a provider that is not in compliance with federal medicaid participation requirements. Department sanctions or actions may include imposition of any remedy or combination of remedies provided by state or federal law and regulations, including but not limited to federal regulations at 42 CFR 488, subpart F.

(3) A provider must provide the department with 30 days advance written notice of termination of participation in the medicaid program. Notice will not be effective prior to 30 calendar days following actual receipt of the notice by the department. Notice must be mailed or delivered to the Department of Public Health and Human Services, Senior and Long Term Care Division, 111 N. Sanders, P.O. Box 4210, Helena, MT 59604-4210.

(a) For purposes of (3), termination includes a cessation of provision of services to medicaid residents, termination of the provider's business, a change in the entity administering or managing the facility or a change in provider as defined in ARM 37.40.325.

(b) In the event that discharge or transfer planning is necessary, the provider remains responsible to provide for such planning in an orderly fashion and to care for its residents until appropriate transfers or discharges are effected, even though transfer or discharge may not have been completed prior to the facility's planned date of termination from the medicaid program.

(c) Providers terminating participation in the medicaid program must prepare and file, in accordance with applicable cost reporting rules, a close out cost report covering the period from the end of the provider's previous fiscal year through the date of termination from the program. New providers assuming operation of a facility from a terminating provider must enroll in the medicaid program in accordance with applicable rules.

(4) A provider must notify a resident or the resident's representative of a transfer or discharge as required by 42 CFR

483.12(a)(4), (5) and (6). The notice must be provided using the form prescribed by the department. In addition to the notice contents required by 42 CFR 483.12, the notice must inform the recipient of the recipient's right to a hearing, the method by which the recipient may obtain a hearing and that the recipient may represent herself or himself or may be represented by legal counsel, a relative, a friend or other spokesperson. Notice forms are available upon request from the department. Requests for notice forms may be made to the Department of Public Health and Human Services, Senior and Long Term Care Division, 111 N. Sanders, P.O. Box 4210, Helena, MT 59604-4210. (History: Sec. 53-6-108, 53-6-111, 53-6-113 and 53-6-189, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-106, 53-6-107, 53-6-111, 53-6-113 and 53-6-168, MCA; NEW, 1991 MAR p. 2050, Eff. 11/1/91; AMD, 1992 MAR p. 1617, Eff. 7/31/92; AMD, 1994 MAR p. 1881, Eff. 7/8/94; AMD, 1995 MAR p. 1227, Eff. 7/1/95; AMD, 1996 MAR p. 1698, Eff. 6/21/96; AMD, 1999 MAR p. 1393, Eff. 6/18/99; TRANS, from SRS, 2000 MAR p. 489; AMD, 2000 MAR p. 492, Eff. 2/11/00; AMD, 2001 MAR p. 1108, Eff. 6/22/01.)

37.40.307 NURSING FACILITY REIMBURSEMENT (1) For nursing facility services, other than ICF/MR services, provided by nursing facilities located within the state of Montana, the Montana medicaid program will pay a provider, for each medicaid patient day, a per diem rate determined in accordance with this rule, minus the amount of the medicaid recipient's patient contribution.

(2) Effective July 1, 2001, and in subsequent rate years, nursing facilities will be reimbursed using a price-base reimbursement methodology. The rate for each facility will be determined using the operating component defined in (2)(a) and the direct resident care component defined in (2)(b):

(a) The operating component is the same per diem for each nursing facility. It is set at 80% of the statewide price for nursing facility services.

(b) The direct resident care component of each facility's rate is 20% of the overall statewide price for nursing facility services. It is adjusted for the acuity of the medicaid residents served in each facility. The acuity adjustment increases or decreases the direct resident care component in proportion to the relationship between each facility's medicaid

average case mix index and the statewide average medicaid case mix index.

(i) The medicaid average case mix index for each facility to be used in rate setting will be the simple average of each facility's four medicaid case mix indices calculated for the periods of February 1 of the current year and November 1, August 1 and May 1 of the year immediately preceding the current year. The statewide average medicaid case mix index will be the weighted average of each facility's four quarter average medicaid case mix index to be used in rate setting.

(c) The rate setting methodology effective July 1, 2001, will hold nursing facilities harmless. To the extent that a provider's rate could decrease using the price-based reimbursement methodology described in this rule, each facility will receive the greater of their price-based rate or their rate in effect on June 30, 2001 increased by 2%. This hold harmless methodology, which provides for a minimum 2% rate increase each state fiscal year, will be in effect for state fiscal years 2002 and 2003. For state fiscal year 2004, or at such time as all facilities have moved to the price, each facility will be reimbursed according to the price-based nursing facility reimbursement system.

(d) The statewide price for nursing facility services will be determined each year though a public process. Factors that could be considered in the establishment of this price include the cost of providing nursing facility services, medicaid recipients access to nursing facility services, and the quality of nursing facility care.

(e) The total payment rate available for the period July 1, 2001 through June 30, 2002 will be the rate as computed in (5), plus any additional amount computed in ARM 37.40.311.

(3) For providers who, as of July 1 of the rate year, have not filed with the department a cost report covering a period of at least six months participation in the medicaid program in a newly constructed facility shall have a rate set at the statewide median price as computed on July 1, 2001 for this transition year. Following a change in provider as defined in ARM 37.40.325, the per diem rate for the new provider shall be set at the previous provider's rate, as if no change in provider had occurred.

(4) For ICF/MR services provided by nursing facilities

located within the state of Montana, the Montana medicaid program will pay a provider as provided in ARM 37.40.336.

(5) In addition to the per diem rate provided under (2) or the reimbursement allowed to an ICF/MR provider under (4), the Montana medicaid program will pay providers located within the state of Montana for separately billable items, in accordance with ARM 37.40.330.

(6) For nursing facility services, including ICF/MR services, provided by nursing facilities located outside the state of Montana, the Montana medicaid program will pay a provider only as provided in ARM 37.40.337.

(7) The Montana medicaid program will not pay any provider for items billable to residents under the provisions of ARM 37.40.331.

(8) Reimbursement for medicare co-insurance days will be as follows:

(a) for dually eligible medicaid and medicare individuals, reimbursement is limited to the per diem rate, as determined under (1) or ARM 37.40.336, or the medicare co-insurance rate, whichever is lower, minus the medicaid recipient's patient contribution; and

(b) for individuals whose medicare buy-in premium is being paid under the qualified medicare beneficiary (QMB) program under ARM 37.83.201 but are not otherwise medicaid eligible, payment will be made only under the QMB program at the medicare coinsurance rate.

(9) The department will not make any nursing facility per diem or other reimbursement payments for any patient day for which a resident is not admitted to a facility bed which is licensed and certified as provided in ARM 37.40.306 as a nursing facility or skilled nursing facility bed.

(10) The department will not reimburse a nursing facility for any patient day for which another nursing facility is holding a bed under the provisions of ARM 37.40.338(1), unless the nursing facility seeking such payment has, prior to admission, notified the facility holding a bed that the resident has been admitted to another nursing facility. The nursing facility seeking such payment must maintain written documentation of such notification.

(11) Providers must bill for all services and supplies in accordance with the provisions of ARM 37.85.406. The

department's fiscal agent will pay a provider on a monthly basis the amount determined under these rules upon receipt of an appropriate billing which reports the number of patient days of nursing facility services provided to authorized medicaid recipients during the billing period.

(a) Authorized medicaid recipients are those residents determined eligible for medicaid and authorized for nursing facility services as a result of the screening process described in ARM 37.40.101, 37.40.105, 37.40.106, 37.40.110, 37.40.120, and 37.40.201, et seq.

(12) Payments provided under this rule are subject to all limitations and cost settlement provisions specified in applicable laws, regulations, rules and policies. All payments or rights to payments under this rule are subject to recovery or non-payment, as specifically provided in these rules. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 1991 MAR p. 2050, Eff. 11/1/91; AMD, 1992 MAR p. 1617, Eff. 7/31/92; AMD, 1993 MAR p. 685, Eff. 4/30/93; AMD, 1993 MAR p. 1385, Eff. 7/1/93; AMD, 1995 MAR p. 1227, Eff. 7/1/95; TRANS, from SRS, 2000 MAR p. 489; AMD, 2000 MAR p. 492, Eff. 2/11/00; AMD, 2000 MAR p. 1754, Eff. 7/14/00; AMD, 2001 MAR p. 1108, Eff. 6/22/01; AMD, 2002 MAR p. 1767, Eff. 6/28/02.)

37.40.308 RATE EFFECTIVE DATES (1) A provider's per diem rate effective for the rate period July 1, 2001 through June 30, 2002 and in subsequent rate years, shall be determined in accordance with ARM 37.40.307.

(2) Except as specifically provided in these rules, per diem rates and interim rates are set no more than once a year, effective July 1, and remain in effect at least through June 30 of the following year.

(a) Nothing in this subchapter shall be construed to require that the department apply any inflation adjustment, recalculate the medicaid case mix index or the statewide price, or otherwise adjust or recalculate per diem rates or interim rates on July 1 of a rate year, unless the department adopts further rules or rule amendments providing specifically for a rate methodology for the rate year.

(3) A provider's rate established July 1 of the rate year shall remain in effect throughout the rate year and throughout subsequent rate years, regardless of any other provision in this

subchapter, until the effective date of a new rate established in accordance with a new rule or amendment to these rules, adopted after the establishment of the current rate, which specifically provides a rate methodology for the new or subsequent rate year. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-6-101 and 53-6-113, MCA; NEW, 1991 MAR p. 2050, Eff. 11/1/91; AMD, 1992 MAR p. 1617, Eff. 7/31/92; AMD, 1998 MAR p. 1749, Eff. 6/26/98; AMD, 1999 MAR p. 1393, Eff. 6/18/99; TRANS, from SRS, 2000 MAR p. 489; AMD, 2000 MAR p. 1754, Eff. 7/14/00; AMD, 2001 MAR p. 1108, Eff. 6/22/01; AMD, 2002 MAR p. 1767, Eff. 6/28/02.)

Rules 09 and 10 reserved

37.40.311 RATE ADJUSTMENT FOR COUNTY FUNDED RURAL NURSING FACILITIES (1) For state fiscal year 2003, the department will provide a mechanism for a one time, lump sum payment during the last quarter of the state fiscal year, to non-state governmental owned or operated facilities for medicaid services. These payments will be for the purpose of maintaining access and viability for a class of "at risk" county affiliated facilities who are predominately rural and are the only nursing facility in their community or county or who provide a significant share of nursing facility services in their community or county.

(a) A nursing facility is eligible to participate in this lump sum payment distribution if it is a non-state governmental owned or operated facility.

(b) The department will calculate the amount of lump sum distribution that will be allowed for each county affiliated provider so that the total per day amount does not exceed the computed medicare upper payment limit for these providers. Distribution of these lump sum payments will be based on the medicaid utilization at each participating facility for the period July 1, 2002 through June 30, 2003.

(c) In order to qualify for this lump sum adjustment effective July 1, 2002, each non-state governmental owned or operated facility must enter into a written agreement to transfer local county funds to be used as matching funds by the department. This transfer option is voluntary, but those facilities that agree to participate must abide by the terms of the written agreement.

(2) Effective for the period commencing on or after July 1, 2002, the department will provide for a one time, lump sum distribution of funding to nursing facilities not participating in the funding for "at risk" facilities for the provision of Medicaid services.

(a) The department will calculate the maximum amount of the lump sum payments that will be allowed for each participating non-state governmental owned or operated facility, as well as the additional payments for other nursing facilities not participating in the funding for "at risk" facilities for the provision of Medicaid services, in accordance with state and federal laws, as well as applicable Medicare upper payment limit thresholds. This payment will be computed as a per day add-on. Distribution will be in the form of lump sum payments and will be based on the Medicaid utilization at each participating facility for the period July 1, 2002 through June 30, 2003. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 2000 MAR p. 1754, Eff. 7/14/00; AMD, 2001 MAR p. 1108, Eff. 6/22/01; AMD, 2002 MAR p. 1767, Eff. 6/28/02.)

Rule 12 reserved

37.40.313 OPERATING COST COMPONENT (REPEALED) (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 1991 MAR p. 2050, Eff. 11/1/91; AMD, 1992 MAR p. 1617, Eff. 7/31/92; AMD, 1993 MAR p. 685, Eff. 4/30/93; AMD, 1993 MAR p. 1385, Eff. 7/1/93; AMD, 1994 MAR p. 1881, Eff. 7/8/94; AMD, 1995 MAR p. 1227, Eff. 7/1/95; AMD, 1996 MAR p. 1698, Eff. 6/21/96; AMD, 1997 MAR p. 1044, Eff. 6/24/97; AMD, 1998 MAR p. 1749, Eff. 6/26/98; AMD, 1999 MAR p. 1393, Eff. 6/18/99; TRANS, from SRS, 2000 MAR p. 489; REP, 2002 MAR p. 1767, Eff. 6/28/02.)

37.40.314 DIRECT NURSING PERSONNEL COST COMPONENT (REPEALED) (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 1991 MAR p. 2050, Eff. 11/1/91; AMD, 1992 MAR p. 1617, Eff. 7/31/92; AMD, 1993 MAR p. 1385, Eff. 7/1/93; AMD, 1994 MAR p. 1881, Eff. 7/8/94; AMD, 1995

MAR p. 1227, Eff. 7/1/95; AMD, 1996 MAR p. 1698, Eff. 6/21/96; AMD, 1997 MAR p. 1044, Eff. 6/24/97; AMD, 1998 MAR p. 1749, Eff. 6/26/98; AMD, 1999 MAR p. 1393, Eff. 6/18/99; TRANS, from SRS, 2000 MAR p. 489; REP, 2002 MAR p. 1767, Eff. 6/28/02.)

37.40.315 STAFFING AND REPORTING REQUIREMENTS

(1) Providers must provide staffing at levels which are adequate to meet federal law, regulations and requirements.

(a) Each provider must submit to the department within 10 days following the end of each calendar month a complete and accurate form DPHHS-SLTC-015, "Monthly Nursing Home Staffing Report" prepared in accordance with all applicable department rules and instructions. Copies of form DPHHS-SLTC-015 may be obtained from the Department of Public Health and Human Services, Senior and Long Term Care Division, 111 N. Sanders, P.O. Box 4210, Helena, MT 59604-4210.

(b) If complete and accurate copies of form DPHHS-SLTC-015 are not received by the department within 10 days following the end of each calendar month, the department may withhold all payments for nursing facility services until the provider complies with the reporting requirements in (1)(a). (History: Sec. 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-108, 53-6-111 and 53-6-113, MCA; NEW, 1991 MAR p. 2050, Eff. 11/1/91; AMD, 1994 MAR p. 1881, Eff. 7/8/94; AMD, 1998 MAR p. 1749, Eff. 6/26/98; AMD, 1999 MAR p. 1393, Eff. 6/18/99; TRANS, from SRS, 2000 MAR p. 1653, Eff. 6/30/00; AMD, 2002 MAR p. 1767, Eff. 6/28/02.)

Rules 16 through 19 reserved

37.40.320 MINIMUM DATA SET SUBMISSION, TREATMENT OF DELAYS IN SUBMISSION, INCOMPLETE ASSESSMENTS, AND CASE MIX INDEX CALCULATION (1) Nursing facilities shall submit all minimum data set assessments and tracking documents to the health care financing administration (HCFA) database as required by federal participation requirements, laws and regulations.

(2) Submitted assessment data shall conform to federal data specifications and meet minimum editing and validation requirements.

(3) Retention of assessments on the database will follow the records retention policy of the department of public health

and human services. Back up tapes of each rate setting period will be maintained for a period of five years.

(4) Assessments not containing sufficient in-range data to perform a resource utilization group-III (RUG-III) algorithm will not be included in the case mix calculation during the transition period.

(5) All current assessments in the database older than six months will be excluded from the case mix index calculation.

(6) For purposes of calculating rates, the department will use the RUG-III, 34 category, index maximizer model, version 5.12. The department may update the classification methodology to reflect advances in resident assessment or classification subject to federal requirements.

(7) For purposes of calculating rates, case mix weights will be developed for each of the 34 RUG-III groupings. The department will compute a Montana specific medicaid case mix utilizing average nursing times from the 1995 and the 1997 HCFA case mix time study. The average minutes per day per resident will be adjusted by Montana specific salary ratios determined by utilizing the licensed to non-licensed ratio spreadsheet information.

(8) For purposes of calculating rates, the department shall assign each resident a RUG-III group calculated on the most current non-delinquent assessment available on the first day of the second month of each quarter as amended during the correction period. The RUG-III group will be translated to the appropriate case mix index or weight. From the individual case mix weights for the applicable quarter, the department shall determine a simple facility average case mix index, carried to four decimal places, based on all resident case mix indices. For each quarter, the department shall calculate a medicaid average case mix index, carried to four decimal places, based on all residents for whom medicaid is reported as the per diem payor source any time during the 30 days prior to their current assessment.

(9) Facilities will be required to comply with the data submission requirements specified in this rule and ARM 37.40.321. The department will utilize medicaid case mix data in the computation of rates for the period July 1, 2001 through June 30, 2002 and for rate years thereafter. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 1999 MAR p. 1393, Eff. 6/18/99; TRANS, from SRS,